



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Kinnegad Centre
Name of provider:	Muiríosa Foundation
Address of centre:	Westmeath
Type of inspection:	Unannounced
Date of inspection:	26 June 2026
Centre ID:	OSV-0005824
Fieldwork ID:	MON-0050757

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Kinnegad Centre is a dormer bungalow located approximately 2km from the local town. Kinnegad Centre is a full time community house which is based on a social model of support. The building design is currently suitable for individuals with high support needs and can accommodate four individuals. There are five bedrooms, four downstairs and one upstairs. The bedroom upstairs is used as a staff sleepover room. There is a large entrance hall and wide corridors. There is an open plan kitchen and dining, a utility, and a sitting room. To the rear of the house is a large fenced garden with patio area and a lawn area to the front of the house. All entrances are wheelchair accessible. Services are provided from the designated centre to both male and female adults. 24 hour support is provided by staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4
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How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Friday 26 June 2026	10:30hrs to 19:30hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was carried out with a specific focus on safeguarding, to ensure that residents felt safe in the centre. Over the preceding months, the Office of the Chief inspector had received solicited information in relation to on going safeguarding concerns occurring in the centre.

Overall, the inspection showed that although aspects of care and support were meeting the assessed needs of the residents, the resident group was incompatible and peer to peer incidents were occurring within the centre. Significant improvements were required in relation to the governance and management systems. Additionally, improvements were required in areas of staffing training and maintenance of aspects of the premises.

Kinnegad Centre is a two-storey house that is located in a rural setting outside a small town in Co. Westmeath. The centre is currently registered for up to four adults and on the day of this inspection there were no resident vacancies.

On the day of this inspection the inspector had the opportunity to meet with and speak to all four residents in the centre. One resident was not present in the centre and the inspector had the opportunity to have a phone call with this resident. The inspector also met with and spoke to the person in charge, residential leader and members of the front line staff team.

On arrival at the centre the inspector was met by one of the front line team and the residential leader. The inspector completed a walk around of the centre with the residential leader. The inspector observed that although the centre was warm and homely some notable damage was apparent on aspects of the premises that required to be addressed. The inspector observed the centre was well decorated and each resident had their own bedroom that was individually decorated to residents liking. The inspector observed that bedrooms were also laid out to meet the individual mobility and medical needs of residents.

The inspector met with two residents in the morning of the inspection. Both residents appeared to be very happy and comfortable in the presence of the staff team. The inspector observed staff taking additional measures to ensure residents were comfortable. For example, the day of this inspection was particularly hot and staff had a number of fans in place to keep residents cool. Later in the afternoon one resident came home from day service. The inspector observed the resident chatting to staff about their day. As previously mentioned one resident was not present and the inspector spoke with them on the phone.

One resident told the inspector that while they were very happy with certain aspects of their home, such as their bedroom, the staff team and the activities they participate in, they did not feel safe in their home. The resident told the inspector

about compatibility issues that led to incidents where they did not feel safe. The resident told the inspector that they did not like some of the reactive strategies in place if an incident did occur. For example, the resident spoke of staff supporting the resident to move away from the area of an incident, but the resident told the inspector they do not like to move from that area.

The inspector observed that the residents in the centre were active members of their community. The inspector observed evidence of residents attending local clubs, going on holidays, attending day services in line with their wishes and, maintaining strong family connections where they wish.

Staff who met with the inspector were knowledgeable in terms of important safeguarding and medical care plans and spoke warmly of the residents. The inspector found that staff showed a strong knowledge of the personalities of the residents and were mindful of the different capabilities of each resident. The staff also showed an understanding of the safeguarding systems and key safeguarding personnel linked to the centre.

Overall, the inspection showed while there are many positive aspects to the lived experiences of the residents. However, there are times when residents are not safe and protected in their home due to ongoing compatibility issues.

The next two sections of this report will outline in greater detail the governance and management systems used by the provider and how these systems impact on the quality and safety of care provided to the residents.

Capacity and capability

Overall, it was found that the governance and management systems within the centre had not been effective. There had been staff vacancies at a local management level which had resulted in gaps on oversight. While it is acknowledged the provider had recruited to fill these positions, a number of improvements were required to ensure that effective and robust oversight was in place at all times.

The provider's auditing and monitoring systems were in place but had not been utilised effectively to ensure the timely identification of issues and the sharing of key information with the staff team and senior management.

Improvements were required in the training analysis and delivery systems to ensure all staff have the required training to meet the assessed needs of the residents. Additionally, continuity of care was not in place at the time of inspection.

Regulation 15: Staffing

While the provider had a suitable mix in terms of grade and number of staff in the centre, the inspection showed an over reliance on agency and relief staff that meant the residents were not at all times provided with a continuity of care. On the day of the inspection there were no staffing vacancies, however, there were staff on long term sick leave.

The provider had ensured that planned and actual rosters were available in the centre. Rosters were maintained by the residential leader as part of their oversight and responsibility roles. On the day of this inspection the inspector reviewed rosters from April and May 2026. On review of the rosters the inspector observed the following:

- the centre was staffed by a mix of staff nurses, social care workers and direct support workers
- agency and relief staff were used each week of the rosters reviewed with multiple different staff working in the centre
- staff worked a mix of day shifts and waking night duties, day staff worked 08:00-20:00 and night staff worked 20:00-08:00
- the provider had removed a sleep over shift and replaced this with an additional waking night duty due to changing needs

The inspector observed that the provider had covered all shifts of the rosters reviewed with no occasions where staffing levels fell below the required number to meet the assessed needs of the residents.

The inspector asked to review the documents retained by the provider in relation to Schedule 2 for three of the staff team. The inspector observed the provider had obtained the garda vetting, photographic Identification, qualifications and references for the staff requested in line with the regulatory requirements.

The staff team were provided with professional supervision in line with the provider's policy. The inspector reviewed the supervision records of three staff and observed the records to be of a high quality that were person centred to each staff member. Staff who spoke with the inspector were complimentary of the supervision process.

Overall, the provider had an appropriate number and skill mix of staff that who supervised and vetted in line with regulatory requirements, however, there was an over-reliance on the use of agency and relief staff each week which reduced the continuity of care for residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had not ensured that the staff team were provided with the required training and education that afforded them the skills and knowledge to meet the residents' assessed needs.

The provider had a training matrix in the centre that evidenced the mandatory, centre specific and refresher training provided to staff. On the day of this inspection the inspector reviewed the training matrix and observed that the staff team had not been in receipt of a number of key trainings required for this centre and at the time of identifying the gaps in training there was no plans for staff to attend the required training. The inspector was informed by the end of the inspection that additional dates had now been scheduled for the staff to attend workshops of the identified training.

The inspector observed that the provider had not ensured all staff were trained in:

- Lamh (a communication method used by persons with additional speech requirements)
- communication
- positive behaviour support

In reviewing care plans and risk assessments, the inspector observed that Lamh training was a recommended training for the staff team. The inspector also observed that the centre had ongoing issues with safeguarding and peer to peer incidents, however, not all staff had received the required training in positive behaviour support.

The inspection showed that the training needs analysis and planning of training were not effective in ensuring the staff team were equipped to meet the assessed needs of the residents.

Judgment: Not compliant

Regulation 23: Governance and management

The inspection showed that the provider did not have effective systems in place to ensure effective oversight of the centre and key centre meetings were observed to not be effective in the sharing of key information.

The centre had recently gone through a number of person in charge changes. The change in personnel meant that gaps had occurred in key areas of oversight. For example, the current governance arrangements meant that local governance meetings were not taking place. The provider had a monthly template that should have been completed by the local manager and forwarded to the provider's senior

manager for the area. However, due to gaps in the local management structure these templates had not been completed since February 2026. As a result this important pathway for local information to reach a more senior level could not always be guaranteed.

While the provider had systems in place to audit and monitor the centre, these systems were not effective. On the day of this inspection the inspector reviewed the provider's annual review, governance meetings, team meetings and unannounced audits completed by the provider every six months.

On review of key reports that audited the quality and safety of care, such as the annual review and provider-led six monthly audit it was noted that neither report outlined sufficiently the ongoing safeguarding and compatibility concerns, nor the impact of the governance arrangements at the times of the audits were having on the centre. Additionally, these audits had not identified areas of improvement as identified on this inspection. For example, a number maintenance issues had been identified in this report. It was clear to the inspector that these issues had been present for some time. However, the providers annual review which was completed in March 2026 only referred to painting required outside and did not refer to any of the internal works that were required.

The inspector reviewed team meetings from March and April 2026 and observed that they were not attended by the majority of the staff team. The inspector also observed that while there was a sign sheet attached for staff to sign when they have read the minutes this was not signed by all members of the team, in particular by those staff who had not attended meetings. The inspector also noted that updates from agenda items discussed were generic. For example, while safeguarding was a standing item, the update for in meeting minutes stated "all safeguarding has been discussed". As a result of limited staff attending meetings and a reliance on agency and relief staff, not all staff were aware of key information regarding safeguarding issues in the centre.

In summary, the governance and management systems were not effective in identifying areas of improvement and there had been gaps in oversight which was having a direct impact on aspects of the lived experience of residents.

Judgment: Not compliant

Quality and safety

While the provider had taken measures to mitigate and reduce the impact of ongoing compatibility issues, incidents were still occurring which was resulting in residents' not being safe in their home at all times.

The provider was required to improve the training in behaviour support to ensure full compliance with the regulation. The provider was also required to carry out long standing maintenance repairs in the centre.

The provider had strong systems in place regarding risk management, individual assessments, care plans and residents' rights. Staff were guided on key areas of risk and given clear guidance on how residents preferred to be supported regarding health and social care needs.

Residents were involved in the decision making regarding their home via weekly resident meetings.

Regulation 10: Communication

The provider had ensured that residents had communication assessments in place that guided staff practice.

Each resident had reviewed had a communication assessment that had been completed by the provider's speech and language therapist in 2024. The inspector also observed that each resident had been referred to the provider's speech and language team for updated assessments. Residents also had individual communication care plans in their person centred plan that were last reviewed in March and May 2026. On the day of this inspection the inspector reviewed the speech and language assessments and corresponding care plans for two residents.

The inspector observed that staff were given information on how residents' communicate, what resident communications may mean and what staff are required to do depending on resident communications. The inspector observed the use of visuals in the centre such as easy reads, visual rosters and visual meal planners.

The assessments and care plans reviewed by the inspector made recommendations regarding the use of objects of reference and staff training. While the inspector observed the use of objects of reference for residents, the recommended training was not in place for all staff. This has been addressed under Regulation 16: Staff Training and Development.

Judgment: Compliant

Regulation 17: Premises

The inspector completed a walk-around of the premises with the residential leader on arrival at the centre. While the centre was observed to be warm, homely and decorated to residents liking, the inspector observed significant damage to walls,

door frames and doors throughout the ground floor. The inspector also observed tears to some furniture items in the centre.

The inspector observed that each resident had their own bedroom that was decorated in line with their individual liking. Resident bedrooms and bathrooms were laid out to meet the assessed needs of the residents, for example, the inspector observed hoists had been installed where required. The inspector observed residents had adequate space for belongings. Residents also had access to mobile phones, internet and smart technology in line with their preferences.

The inspector observed that the provider ordered new furniture that was being delivered to replace furniture items that were torn. The provider had also in recent days been in receipt of a new comfy chair for one resident that replaced an old and worn comfy chair.

The inspector observed significant damage had been to the majority of the downstairs door frames, walls and doors from a residents wheelchair. It was clear to the inspector that the damage had been present for some time. While the provider was able to show the inspector evidence that the damage had now been reported to the providers maintenance team, this had only recently been escalated despite being present for some time.

In summary, in the main the residents home was well decorated and laid out to meet the assessed needs of the residents, the lack of oversight systems in the centre meant maintenance items were not reported and rectified in a timely manner.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The centre had a comprehensive risk register that outlined key risks for each individual resident and for the centre. The centres risk register was maintained by centre management and risk assessments were reviewed in line with the providers policy. The risk assessments reviewed by the inspector were all reviewed in March 2026.

On the day of this inspection the inspector reviewed a sample of risk assessments in place for each resident and centre specific assessments.

The inspector observed assessments in place for areas such as:

- falls
- seizure activity
- living with others
- manual handling
- skin integrity
- fire safety

- distress behaviours

The inspector observed control measures in each assessment that were proportionate to the level of risk and effective in mitigating the risk. For example, in reviewing a risk assessment for a resident displaying distress behaviours, a control measure noted by the inspector was for staff to offer assistance based on the response of the resident. The inspector observed the staff team offering choice to the resident throughout the afternoon of the inspection with staff only offering assistance when the resident agreed.

Overall, the inspector observed strong risk management practices that informed staff on the agreed measures used to mitigate risk in the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

On the day of this inspection the inspector reviewed care plans for each resident in the centre. The inspector observed that each resident had a comprehensive individual suite of assessments and care plans that detailed their health and social care needs.

In reviewing the resident files the inspector observed assessments and plans for key areas such as:

- percutaneous endoscopic gastronomy (PEG) site management
- eating and drinking
- epilepsy
- mobility
- maintaining a safe environment

The inspector reviewed care plans in place for epilepsy and PEG site management in greater detail. The inspector observed staff were guided and informed on:

- types of seizures residents have
- when to call for additional medical assistance
- how to clean a PEG site daily
- what type of feed to use and how to ensure safe feeding

Staff who met with the inspector displayed a clear knowledge of key details in resident care plans. In particular staff displayed a thorough knowledge of a residents PEG site management. This was an important plant to be aware of as the centre had limited staff nurse cover and the resident requiring detailed daily maintenance of the PEG site.

In summary, care plans were observed to be person centered and contained enough detail for the staff team to effectively manage complex health conditions safely in the residents home.

Judgment: Compliant

Regulation 7: Positive behavioural support

While the provider had a comprehensive behaviour support plans in place where required, not all staff had been in receipt of the required training to implement the strategies outlined in the resident plans.

On the day of this inspection the inspector reviewed the behaviour support plan in place for one resident who required this type of plan. The inspector observed the plan had been completed by the provider's behaviour support specialist. It discussed important areas such as background information relating to the resident, how to manage signs of distress, how to manage the environment and, the importance of choice for the resident.

While the behaviour support plan in place was comprehensive and detailed a number of key strategies in place, the inspector observed that just seven of the staff team had received the required positive behaviour support training. It was evident given the safeguarding and peer to peer incidents occurring in the centre this was an important training for the staff team.

The provider had ensured to keep an accurate recording of all incidents that were occurring in the centre, this included incidents that were a result of behaviours of concern. The inspector reviewed the incident reports for 2026 in the centre.

Incident reviews were carried out in a timely manner after each incident and were signed by centre management. For example, after one significant incident in April 2026 the inspector observed a comprehensive review of the incident and that the resident's plan that included input from the provider's behaviour support specialist and staff team.

Overall, while it was clear there was a comprehensive system in place regarding the planning of resident behaviour support needs and the accurate reporting of incidents, not all staff had received appropriate behaviour support training. This meant that the provider could not assure themselves that all incidents could be managed in line with agreed strategies. Considering the ongoing incompatibility between residents and incidents in relation to this, it was essential that all staff were equipped with the knowledge and skills to de-escalate any incidents that were occurring.

Judgment: Substantially compliant

Regulation 8: Protection

Although the provider had taken a number of measures to safeguard the residents, the inspection showed ongoing compatibility issues that meant residents were not always safe in their home.

From a review of incidents that had occurred in the centre in 2026 the inspector observed peer to peer incidents had occurred in every month of 2026. One resident who spoke to the inspector outlined that they did not feel safe at all times.

The provider was in the process of a comprehensive review of resident compatibility in the centre. The inspector reviewed the compatibility assessments completed in which the provider had acknowledged the residents were no longer compatible with residents citing noise and behaviours as areas of concern.

The provider had a comprehensive safeguarding log in place that detailed each safeguarding incident that occurred in the centre. Each incident had a safeguarding plan and there remained open safeguarding plans in place on the day of the inspection. The inspector reviewed safeguarding plans and observed detailed control measures such as 1:1 time with staff, residents attending different day services, the use of easy reads, multi-disciplinary team input and positive reinforcement. The inspector observed the ongoing implementation of control measures for example, the inspector observed easy reads on residents respecting each other, staff used positive reinforcement throughout the inspection and residents were informed when safeguarding concerns were submitted on their behalf.

The inspector also observed that the staff team had all completed safeguarding training. The provider had ensured key safeguarding information was located in prominent areas of the centre such as the designated officer details and information regarding advocacy services.

Staff who met with the inspector were knowledgeable in terms of their role regarding safeguarding. Staff spoke competently regarding the safeguarding systems in the centre including the reporting structure, the types of safeguarding incident in the centre and who the providers designated office was.

In summary, it was evident to the inspector that the provider had taken the ongoing safeguarding and compatibility concerns seriously. The provider had made changes to the staff roster and implemented all actions in safeguarding plans in an attempt to keep residents safe. However, it was evident from a review of incidents, speaking with residents and reviewing compatibility assessments that peer to peer incidents were continuing in the centre. Further actions were required in this area to address this area of concern and to ensure residents were safe at all times.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The inspector observed evidence that the provider was operating the centre in a manner that promoted and respected residents rights.

The inspector observed that the staff team had completed training in residents rights. Staff who spoke with the inspector were knowledgeable in terms of supporting residents to make choices and ensuring that residents received information in a format that was accessible to them.

The provider ensured that weekly resident meetings were occurring in the centre and the inspector reviewed the minutes of these meetings for the months of May and June 2026. The inspector observed that residents were involved in the running of the centre with a review of the past week and planning for the week ahead. Residents could choose activities and meals for the week ahead of their choosing.

The inspector also observed a discussion around the topic of the week. The inspector observed that this was linked to key issues currently in the centre. For example, key topics such as healthy eating, positive relationships and kindness and friendship were discussed. The inspector observed residents were shown an easy read on positive relationship and also watched on-line videos of the same topic ensuring the information was in a format that suited all residents.

The inspector observed that residents were involved in a wide variety of activities that were based on their likes and dislikes. For example, in one resident's bedroom there was evidence that the resident had a strong religious faith. Recently the resident had been on a trip to Knock.

A resident also had a diagnosis of diabetes and the inspector observed that the resident had been attended a diabetes course. The inspector observed other activities such as shopping, going for a coffee, reflexology and music therapy.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kinnegad Centre OSV-0005824

Inspection ID: MON-0050757

Date of inspection: 26/06/2026

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The PIC ensures that rosters are planned in advance. All staff vacancies are identified to the area director and human resources dept as soon as they become known. Recruitment campaigns for all grades of staff are continuous in the organisation. Where staff vacancies arise due to unforeseen circumstances EG: Sick leave, the PIC has access to a bank of regular relief staff who are familiar with the location and have received induction and training. However, the use of unfamiliar agency staff at times is unavoidable. At these times there is a local protocol in place to ensure the minimum disruption to residents.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has ensured all communication support plans for all residents are reviewed in full by keyworkers. All staff on the team are attending Total Communication training on 06/08/2026. Staff currently out of date for Positive Behavioural Support training are scheduled for 10th Sept & 6th Oct.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Governance in the location is managed through the following structures; 1. The Area Director meets the Regional Director monthly for formal area updates and daily for informal support and guidance. 2. Emerging high risks are assessed and escalated to the regional director appropriately depending on risk rating. The regional director escalates to the senior leadership team as required. 3. The PIC and residential leader meet weekly and maintain daily contact for support and guidance. 4. The residential leader ensures that the monthly governance report is submitted for review by the regional director. 5. All required notifications are made regarding safeguarding/ health & Safety/ risk management. 6. A support and supervision structure is in place for frontline staff/ team leader/ residential leader/ PIC. The Annual Review template and 6 monthly templates have been reviewed and updated by the Area Director to ensure all risks in the location for the previous year are captured and appropriate actions identified. The PIC has reviewed the structure of all staff team meetings to ensure minutes and actions arising are comprehensive and adequately detail the content of the meeting. Team meetings are rostered in monthly; all staff are rostered to attend in person unless on leave. Staff on leave are required to read/ sign & date meeting minutes on their return.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: All damaged furniture in communal areas in the house has been replaced. The PIC has followed up with the maintenance department and requested for all damage to walls, door frames and doors throughout the ground floor are repaired.	

Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The PIC has followed up with the training department and all staff currently out of date for Positive Behavioural Support training are scheduled for 10th Sept & 6th Oct.	
Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: A Multi-Disciplinary Team meeting was held on 06/07/2026 attended by The PIC/ Area Director/ Area Leader/ Residential Leader/ Team Leader/ Safeguarding Designated Officer/ Regional Director/ Behavioural Psychologist/ Clinical Psychologist/ Occupational Therapist/ Physiotherapist, to review the compatibility assessments for all residents in the location. PIC and Residential leader have completed a review of all incidents to identify trends/ high risk times and locations in the house. Behavioural psychologists support the residential leader to explore with individual residents the kind of residential service they want and require based on their changing support needs. Residents are facilitated to spend time out of the house and are supported to access their community / family visits supported by staff on a 1:1 basis. The Regional & Area Directors have reviewed the regional transport requirements and identified a 2nd vehicle for the location to support the management of safeguarding. Communication to and for residents is supported with social stories/ behavioural support/ visual timetables and shared resource planning. The Area Director and Regional Director have linked in with the Head of Facilities to discuss options to create an extension or outdoor room, to the house to support residents in having access to separate living spaces. The Regional Director has scheduled to meet with the commissioner for services and the landlord to seek approval to create an additional living space for one resident which would aim to resolve safeguarding concerns and meet the needs of all residents. High levels of staff supervision and support remain in place to support safeguarding and access to the community for all residents. Safeguarding is monitored closely by the Residential Leader and the PIC. The PIC reviews all safeguarding notifications with the Regional Director on a monthly basis. The PIC and the Regional Director attend the quarterly regional Safeguarding Forum with the Safeguarding Designated Officers.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	05/08/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	06/10/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good	Substantially Compliant	Yellow	16/11/2026

	state of repair externally and internally.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	05/08/2026
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Substantially Compliant	Yellow	06/10/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/04/2027